#6150641.0

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

USIDNET Immunodeficiency Patient Registry administered by the Immune Deficiency Foundation

This release authorizes Dr.____
of ____ to release any and all information needed for the completion of the registry data collection forms for the USIDNET Registry of Patients with Primary Immunodeficiency Diseases.

Patient Name: Last ________________ First ________________ Middle _________

(Maiden / other name used) ________________

Date of Birth: ______________

Address: ______________________ Telephone: ________________

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The patient has elected to participate in a National Institutes of Health supported national registry of patients with primary immunodeficiency diseases. The Registry was established with the goal of improving the understanding and treatment of these rare disorders by pooling information gathered from many patients and physicians around the country and the world. It is planned to ask for a data update on an annual basis to provide long term follow-up. Your cooperation with this important program is deeply appreciated.

Please release information contained in the attached document(s) along with a copy of this form to:

USIDNET Registry Manager
40 West Chesapeake Avenue, STE 308
Towson, MD 21204
FAX 410-321-0293

This authorization is effective now and will remain in effect until notice is given to stop the release of data, which I may do at any time in writing. I understand that I have the right to receive a copy of this authorization.

______________________________ Signature of patient or legal representative

______________________________ Date

______________________________ Print name of patient

______________________________ Print name of legal representative